

Editorial

The Medical Costs of Social Deprivation – Whose Job Is it Anyway?

The current issue of *Diabetic Medicine* contains two reports describing increased mortality from diabetes associated with indices of lower social status.^{1,2} This will come as no surprise to clinicians who have despaired of complicated diabetes in people presenting late in their disease, unable or unwilling to seek or use medical advice earlier, or struggled to achieve good control in people whose life circumstances cannot be sorted out by new prescriptions for insulin but resolution of which would achieve a lower glycated haemoglobin than any manipulation of treatment regimen.

Also in this issue are papers examining the predictors of high risk for diabetic complications³ and descriptions of better and more beautiful methods for eye screening.^{4,5} Politicians have been concerned about the possible costs of preventive care in diabetes and certainly do not always find themselves able to fund it. Health economists make their living out of analysing the costs of intensive therapy vs the microvascular disease it might avoid and the expense of new retinal imaging systems vs the blindness to be avoided. But as the technology to deliver health prevention expands and improves, it often seems that the inability of the most vulnerable to access it and benefit from it is not tackled.

It is axiomatic that the seeds for poor health are sown in childhood. This truism predates the Barker-Hales hypothesis but can certainly be informed by it. If Barker and Hales are right, improving women's health may diminish the prevalence of many diseases, including Type 2 Diabetes, in future generations, but whatever one's views on the influence of the intrauterine environment on adult morbidity in 30 years or so, there can be no doubt that improving the external environment could make a very great difference to the burden of diabetic disease very much sooner. What are we doing wrong?

Nilsson and colleagues have used educational attainment as a marker of social status and find a correlation between the two, as do Robinson *et al.* in a different population. In the diabetes world, we spend a lot of time talking about education. Rightly so, but is it possible we are not always focussing on the right sort of education?

Maybe we should be looking more closely at ordinary school education and how we can help future citizens to learn to look after their health, protecting themselves from disease and avoiding disaster when (as some will) they fail. It is whole societies that need the education – so we can together provide the right environment for a healthy population. It is true that throwing money at problems do not make them go away, but not providing enough will certainly make them worse. And why throw it? Careful application would surely be prescribed?

In clinics, poor diabetes control is so often just a marker for poor quality of life. This is not unique to diabetes, and sometimes a doctor may find himself wondering just how far into the patient's social and personal problems his care should go. We are not necessarily well equipped to help with the real problems that beset some of our patients and so often can find no one else to do it better. So we draw limits of medical responsibility and in so doing may draw the plans for our own defeat. It is not as doctors that we need to tackle some of the greatest difficulties for our patients but as citizens. And that means that we should not be tackling these things alone.

References

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